AGING AND DISABILITY SERVICES ADMINISTRATION
HOME AND COMMUNITY SERVICES -- REGIONAL SUPPORT NETWORK

MEDICAID PERSONAL CARE CLIENT RSN TRANSMITTAL

TO:	NAME OF REGIONAL SUPPORT NETWORK WORKER (RSN)	FAX NUMBER	DATE SENT TO RSN
FROM:	NAME OF HCS/AAA WORKER		TELEPHONE NUMBER
	NAME OF HCS/AAA OFFICE		
SUBJECT:	CLIENT NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH

This Transmittal Packet includes this transmittal form and:

- Copy of Comprehensive Assessment (CA)
- Copy of DSHS 14-159, SSPS Authorization form

TO BE COMPLETED BY REGIONAL SUPPORT NETWORK

DATE RECEIVED AT RSN	NAME OF RSN STAFF REVIEWING PACKET	TELEPHONE NUMBER

I have reviewed this packet and find the following:

☐ This client meets eligibility for Medicaid Personal Care services because of psychiatric disabilities and the RSN will pay for this service.

☐ Although this client has unmet needs because of psychiatric disabilities, another RSN service will be provided to meet the client's unmet personal care needs indicated on the client's CA. MPC will not be provided.

☐ This client's eligibility for MPC is not based on a solely psychiatric disability. The RSN will not pay for this service.

COMMENTS:

DSHS 13-712 (02/2003)

Failure to respond by telephone or by returning this transmittal within five working days may trigger authorization of Medicaid Personal Care funded by Regional Support Network